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STATEMENT OF

JONATHAN BLUM

ACTING PRINCIPAL DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR MEDICARE,
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

POST-ACUTE CARE IN THE MEDICARE PROGRAM

BEFORE THE

U. S. HOUSE COMMITTEE ON WAYS AND MEANS, SUBCOMMITTEE ON HEALTH

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Statement of Jonathan Blum on
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House Committee on Ways and Means, Subcommittee on Health
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Chairman Brady, Ranking Member McDermott, and members of the Subcommittee, thank you for this opportunity to discuss spending on post-acute care in the Medicare program, and to highlight the efforts of the Centers for Medicare & Medicaid Services (CMS) to reform payments for post-acute care. Spending on post-acute care services is the greatest source of geographic variation in the Medicare fee-for-service program, but greater spending on these services does not appear to be associated with better health care outcomes. As a result, CMS is aggressively working to better manage Medicare's spending on post-acute care through a series of payment changes, and is conducting ongoing work to develop new payment and delivery system models like Accountable Care Organizations and bundled payments. In addition, the President's FY 2014 Budget includes several important proposals to promote efficiency and improved quality in the post-acute settings. Any effort to reduce overall Medicare spending while improving quality of care must carefully consider Medicare's current policies for post-acute care benefits, and I look forward to working with the Subcommittee on these issues over the coming year.

Post-Acute Care Spending

Post-acute care is the skilled nursing care and therapy typically furnished after an inpatient hospital stay. It is provided in a variety of settings, including skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), long-term care hospitals (LTCHs), and in patients' homes by home health agencies (HHAs). Often provided with the goal of shortening a patient's hospital stay, post-acute care is just one component of a broad care delivery continuum. Unfortunately, care across that continuum can be fragmented, as patients may pass through the care of multiple providers, and the providers may not consistently and accurately communicate information on the course of treatment with all those involved in the patient's care. Additionally, providers face financial incentives that are not always well-aligned with the cost and the quality of patient care. Health care often is not delivered in the most efficient, clinically appropriate, and cost-effective care setting. Post-acute care, in particular, is often delivered in more intensive care settings where Medicare payments are higher, when effective and appropriate care can be

delivered in a lower-intensity setting. Better management of post-acute care will be a key component to any successful effort to reform and improve the Medicare program.

Furthermore, Medicare spending per beneficiary varies widely throughout the country,[1] and geographic variation in spending is particularly high for post-acute care. In 2011, the Medicare Payment Advisory Commission (MedPAC) examined Medicare FFS regional spending variation in three composite sectors: acute inpatient, which included short-term inpatient and psychiatric care; ambulatory, which included physicians, ambulatory surgical centers, and labs within hospital outpatient facilities; and post-acute, which combined HHAs, SNFs, LTCHs, and IRFs. MedPAC's analysis found that the post-acute care sector showed the greatest variation, with spending of $60 per member per month in the lowest-use area to almost $450 in the highest-use area.[2] In 2013, the Institute of Medicine's Committee on Geographic Variation analyzed Medicare post-acute care spending in 2007 through 2009 by SNFs, HHAs, hospices, LTCHs, and IRFs to determine the extent to which variation in post-acute care spending contributes to variation in total, all-cause Medicare spending. The Committee found that 40 percent of all variation in Medicare spending is explained by variation in the utilization of post-acute care services.[3]

Spending patterns across the country for post-acute care following discharge for two different diagnosis-related groups (DRGs) show the extent to which Medicare spending on post-acute care varies by region. For example, for major joint replacement or reattachment of lower extremity without multiple chronic conditions (MS-DRG 470), per capita spending on post-acute care averages $7,114 nationally, including spending at SNFs, IRFs, LTCHs, and by HHAs. However, post-acute care spending for joint replacement, the same MS-DRG-470, across the country varies widely. For an episode of care in Charleston, West Virginia, average spending totals $4,887 per

[1] Centers for Medicare & Medicaid Services (2011). *Health Expenditures by State of Residence.* Retrieved (December 2011) at http://www.cms.gov/NationalHealthExpendData/downloads/resident-state-estimates.zip.
[2] MedPAC (January 2011). *Regional Variation in Medicare Service Use.* pp 6-7. Retrieved (May 24, 2013) at http://www.medpac.gov/documents/Jan11_RegionalVariation_report.pdf
[3] Institute of Medicine (2013) *Interim Report of the Committee on Geographic Variation in Health Care Spending and Promotion of High-Value Health Care: Preliminary Committee Observations*. Retrieved (June 3, 2013) at http://www.iom.edu/Reports/2013/Geographic-Variation-in-Health-Care-Spending-and-Promotion-of-High-Care-Value-Interim-Report.aspx

capita, 30 percent less than the national average. In Hackensack, New Jersey, average spending per episode of care totals $12,862 per capita, or nearly double the national average.[4]

Medicare spending on post-acute care can even vary widely within one state. For intracranial hemorrhage or cerebral infarction with chronic conditions (MS-DRG 65), the national average for Medicare post-acute spending on an episode of care is $12,660. For this episode of care in Temple, Texas, per capita spending totals $5,818, less than half the national average. In Wichita Falls, Texas, however, spending for this type of episode of care totals $18,202 per capita, nearly 150 percent of national average spending.[5] These variations in post-acute Medicare spending are costly for taxpayers and threaten the sustainability of the Medicare trust fund.

In addition to differences in utilization of certain services and in other variables, payment vulnerabilities also contribute to the high degree of variation in post-acute care spending across the country. CMS' program integrity efforts have identified improper billing schemes by post-acute care providers including SNFs billing for services not provided or not medically appropriate; SNFs billing for individual therapy when group therapy was provided; IRFs billing for services rendered without physician orders; HHAs billing for care for beneficiaries who are not homebound; and HHAs purposefully delaying discharge of patients when skilled care is no longer needed. Some of these improper billing practices point to potential overtreatment of Medicare beneficiaries, with patients receiving more intensive care than is medically warranted. They also point to the importance of both anti-fraud efforts as well as improvements in the way CMS pays for post-acute care to incentivize high-quality care delivered in the most appropriate care setting.

CMS' Progress in Addressing Post-Acute Care Spending

To address these longstanding challenges in post-acute care spending, CMS is taking concrete steps to encourage payment accuracy and higher value in post-acute care. Two primary modes of action are direct payment changes through rulemaking, and testing new payment and service

[4] Calculations based on internal analysis using data from the CMS Chronic Condition Warehouse, available at http://www.ccwdata.org/web/guest/home

[5] Calculations based on internal analysis using data from the CMS Chronic Condition Warehouse, available at http://www.ccwdata.org/web/guest/home

delivery models through the Center for Medicare and Medicaid Innovation (CMS Innovation Center).

Direct Post-Acute Care Payment Changes

CMS is aggressively working to better manage Medicare's spending on post-acute care through a series of payment changes. CMS has already made several direct changes to better align post-acute care payments with costs and address payment vulnerabilities, and is continuing to do so through proposed rules on FY 2014 payment rates.

SNF Resource Utilization Group System Refinements

SNF residents are classified into distinct groups based on the relative resource intensity that would typically be associated with each resident's clinical condition, as identified through a resident assessment. The classification groups, referred to as Resource Utilization Groups (RUGs), are used to establish the SNF prospective payment system (PPS) payment. CMS has taken steps to refine the RUGs through the years to pay appropriately for the types of patients using SNF services. The most recent RUG refinement was in FY 2011 when the SNF PPS transitioned from the previous, 53-group refined version 3 of the Resource Utilization Groups (RUG-53) to the new 66-group version 4 (RUG-IV) classification system. The transition from RUG-53 to RUG-IV was intended to be budget-neutral, ensuring that the transition itself would not result in any change in overall Medicare expenditures under the SNF PPS. However, CMS noticed significant changes in SNF provider behavior immediately upon implementation of the new version of the RUGs. Since the SNF PPS rates had been set assuming therapy utilization would decrease under the new RUG system, the rates for FY 2011 were set too high and, rather than maintaining budget neutrality in the transition as intended, actual Medicare expenditures for SNFs during FY 2011 exceeded projected expenditures by $4.47 billion.

In response to this unintended spike in payments, in FY 2012, CMS recalibrated certain case-mix indexes used to determine the per diem rates to restore overall payments to their intended levels on a prospective basis, which equated to a reduction in SNF expenditures of $4.47 billion. In addition, we developed and implemented an active ongoing monitoring program to ensure that the various policy interventions had their intended effect, as well as identify any other changes in

provider behavior. This monitoring shows that beneficiary access has remained stable throughout these interventions.

SNF Therapy Payment Research

Since 1998, Medicare has paid for services provided by SNFs under the Medicare Part A benefit on a per diem basis through the SNF PPS. Currently, the therapy payment rate component of the SNF PPS is based solely on the amount of therapy provided to a patient, regardless of the specific patient characteristics. CMS has contracted with Acumen, LLC and the Brookings Institution to identify potential alternatives to the existing methodology used to pay for therapy services under the SNF PPS. As an initial step, the project will review past research studies and policy issues related to SNF PPS therapy payment and options for improving or replacing the current system of paying for SNF therapy services.

Home Health Therapy Clarifications

CMS has also made post-acute care payment changes in response to data analysis and recommendations from MedPAC. Analysis of 2008 home health data suggested that some HHAs may have been providing unnecessary therapy, and in its March 2010 report, MedPAC suggested this data also revealed a 26 percent increase in episodes with 14 or more therapy visits. These analyses suggested that therapy payment policies were vulnerable to fraud and abuse. They also suggested another fundamental concern—that payment incentives had a significant effect on treatment patterns because the eligibility criteria for the home health benefit were ill-defined.

CMS acted quickly in response to MedPAC's analysis. In calendar year (CY) 2011 rulemaking, we clarified our coverage of therapy services policies to curb misuse of the benefit. Specifically, we required that HHA providers describe measureable treatment goals in a patient's plan of care and measure progress toward achieving those care goals to determine the therapy's effectiveness. To address the delivery of unnecessary therapy services under the HHA prospective payment system, we required that a qualified therapist (instead of an assistant) perform the needed therapy services and assess the patient, measure progress, and document progress toward goals at least once every 30 days during a therapy patient's course of treatment. In addition, for those patients needing 13 or 19 therapy visits, we required a qualified therapist to perform the therapy service

required at the 13th and 19th visit, assess the patient, and measure and document effectiveness of the therapy. Except in cases where the patient meets the criteria for needing maintenance therapy, Medicare would cease coverage of therapy services if progress toward plan of care goals could not be measured or expected in a reasonable and predictable timeframe.

Rebasing the Home Health Payment System

The Affordable Care Act required rebasing the Home Health PPS to reflect such factors as changes in an episode regarding the number of visits, mix and level of intensity of services, the average cost of providing care, and other relevant factors. The rebasing is required to be phased-in in four-year increments with the adjustments fully implemented for 2017. CMS will be proposing these adjustments in this year's rulemaking for CY 2014.

Home Health and Program Integrity

The Affordable Care Act mandated that for a patient to be eligible for the home health benefit, the certifying physician must document that they, or a permitted non-physician practitioner (NPP), had a face-to-face encounter with the patient. In our CY 2011 Final Rule, we finalized a policy to allow the face-to-face encounter to occur up to 90 days prior to the start of care, and up to 30 days after the start of care. In our CY 2012 Final Rule, we allow the patient's acute or post-acute physician to fulfill the requirement of informing the certifying physician of their encounters with the patient to satisfy the face-to-face encounter requirement. These policies ensure flexibility in certifying a patient's eligibility for home health care while ensuring that patients who receive the benefit have a bona fide need.

There are additional Affordable Care Act established safeguards currently in place. For instance, CMS designates newly enrolling HHAs as high risk, flagged for screening and potential administrative actions, including licensure checks, as well as unannounced site visits, and an FBI criminal history record check upon completion of CMS's enrollment process.

LTCH Chronically-Ill and Medically-Complex Criteria

The FY 2014 proposed rule for LTCHs includes research findings on criteria to better identify chronically critically ill and medically complex patients. Typically, these patients are treated in

acute care hospitals and LTCHs, but their predictable and consistent need for extended hospital-level care may be better met through stays in step-down units of inpatient prospective payment system hospitals, or in LTCHs. The proposed rule solicits feedback on the research about this patient population with an eye toward formulating new policy proposals for FY 2015.

Hospice Payment Reform

The Affordable Care Act requires revisions to the methodology for determining hospice payment rates no earlier than October 1, 2013. CMS has been conducting analyses and has solicited stakeholder input on hospice payment reform. The FY 2014 Hospice Wage Index and Payment Rate Update proposed rule provides an update on the hospice payment reform efforts. This update includes data collection efforts, initial findings on rebasing the routine home care rate, and discussion of various payment reform model options, including one recommended by MedPAC in its March 2009 Report to Congress.

Proposed SNF, IRF, LTCH, and Hospice Payment Changes for FY 2014

CMS is also taking active steps to address post-acute care spending through FY 2014 payment rate proposed rules. In April and May 2013, Medicare released proposed rules that would change the way post-acute care is valued and reported and the way post-acute care payments are forecast.

The FY 2014 SNF PPS proposed rule recommends changes in SNF reporting and payment. To ensure accurate case-mix assignment and payment, the proposed rule would add an item to the SNF resident assessment instrument, the Minimum Data Set (MDS) 3.0, which would require providers to record the number of distinct calendar days of therapy provided across all rehabilitation disciplines. Currently, the number of therapy days for each individual therapy discipline reported on the MDS 3.0 is simply summed, resulting in higher SNF payments than are warranted for some patients. The proposed rule would also revise and rebase the SNF market basket, basing it on data from FY 2010. Currently, the market basket index is based on FY 2004 data. The SNF proposed rule would also make a change to the way in which CMS reports the SNF market basket forecast error in certain instances, which would allow CMS to more accurately report the difference between the actual and projected market basket percentage

change in these instances for a given year, and to more accurately determine whether a forecast error correction is warranted.

Also included in Medicare's FY 2014 payment rate rules are proposed changes to update IRF PPS rates. To improve the accuracy of IRF facility-level payment adjustments, the IRF proposed rule would add a new variable in the adjustment methodology to account for whether the IRF is a freestanding hospital or a unit of an acute care or critical access hospital. CMS is also proposing changes in the way inpatient hospitals qualify for higher IRF rates rather than lower hospital inpatient rates. Currently, an inpatient hospital must demonstrate that at least 60 percent of its patients meet criteria including the need for intensive inpatient rehabilitation services for one or more of 13 listed conditions. Compliance is demonstrated through either medical review, or by comparing the patient's diagnosis codes with a list of codes indicating "presumptive compliance." Proposed rules would revise the diagnosis codes on the "presumptive compliance" list so that they better indicate, without the need for further medical review, both the presence of one of the 13 approved conditions *and* the patient's need for intensive rehabilitation.

CMS is also proposing changes to LTCH payment. Under the proposed rules, a LTCH that admits more than 25 percent of its patients from a single acute care hospital would be paid at a rate comparable to inpatient prospective payment system hospitals for those patients above the 25-percent threshold. A statutory moratorium on the enforcement of this policy was in place from December 2007 to December 2012. In FY 2013 rulemaking, CMS extended the moratorium through September 30, 2013, while we continued to research the types of criteria that best identify patients who are appropriately treated in LTCHs.

Medicare's FY 2014 payment rate rules also reflect CMS' ongoing efforts to support beneficiary access to hospice. To gain a better understanding of those who are served by the Medicare hospice program, the rules clarify appropriate diagnosis coding in hospice claims. We propose requiring providers to code the principal diagnosis using the underlying condition that is the main focus of the patient's care, and would not allow for the inappropriate use of non-specific diagnosis codes or codes that are not for the patient's principal diagnosis.

Quality Reporting and Value-Based Purchasing Programs

The Affordable Care Act required CMS to establish in Medicare quality measures and quality reporting programs for IRFs, hospices and LTCHs, with payment adjustments for providers that do not report specified quality data to the Secretary beginning in FY 2014. Tying payment to quality reporting has moved the Medicare program toward rewarding better value, outcomes, and innovations instead of the volume of services provided. The proposed FY 2014 payment rate rules for IRFs, hospices, and LTCHs propose to adopt updated quality measures and changes to quality reporting requirements. These proposals for post-acute care quality reporting, if finalized, will help CMS monitor and assess beneficiary access to high-quality care. In addition, the Affordable Care Act required the Secretary to develop plans for implementing value-based purchasing (VBP) programs for SNFs and home health agencies, and HHS submitted reports to Congress in 2012. VBP has been implemented successfully for the inpatient acute care hospital setting, and creating VBP programs for post-acute care settings would enhance CMS' efforts to improve quality of care.

Delivery System Reforms

In addition to this aggressive management of payment policies, CMS is working to develop and test new delivery system models that will further impact the way post-acute care is delivered. The Affordable Care Act provided CMS with valuable tools to help us research and demonstrate care improvements and lower costs by creating the CMS Innovation Center. The CMS Innovation Center is focused on testing new payment and service delivery models, evaluating results and advancing best practices, and engaging a broad range of stakeholders to develop additional models for testing. Several of the CMS Innovation Center's initiatives test payment and delivery models that include or are specific to post-acute care.

Bundled Payments

CMS recently launched the Bundled Payments for Care Improvement initiative, a new payment model developed by the CMS Innovation Center. Traditionally, Medicare makes separate payments to providers for each of the individual services they furnish to beneficiaries for a single illness or course of treatment. This approach can result in fragmented care and a lack of coordination across health care settings. Research has shown that bundled payments can align

incentives for providers– hospitals, post-acute care providers, physicians, and other practitioners– allowing them to work closely together across all specialties and settings.[6]

The Bundled Payments for Care Improvement initiative is composed of four broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care. Two of the four models include payments for post-acute care. Model 2 makes retrospective bundled payments for acute care hospital stays plus post-acute care. Retrospective payment means that the providers and practitioners are paid as usual until a later reconciliation determines their performance against a target amount. Model 3 also makes retrospective bundled payments, but only for post-acute. For both of these models, an episode of care ends either 30, 60, or 90 days after hospital discharge or post-acute care initiation, respectively, and participants are able to select up to 48 different clinical condition episodes.

CMS is implementing Models 2 and 3 in two phases. CMS is working with participants in the models during an initial period (Phase 1) to prepare for financial and performance accountability for episodes of care prior to the participants potentially being selected by CMS as awardees and entering the "risk-bearing" period of performance (Phase 2). Currently, 55 organizations representing 193 health care facilities are participating in Phase 1 of Model 2. Fourteen organizations representing 166 health care facilities are participating in Phase 1 of Model 3. The "risk-bearing implementation" period, Phase 2, is expected to begin in October 2013. Those participants in Phase 1 of Models 2 and 3 that are ultimately approved by CMS and decide to move forward with assumption of financial risk may enter into an agreement with CMS and begin Phase 2 of the Model. Over the course of the three-year initiative, CMS will work with participating organizations to assess whether the models being tested result in improved patient care and lower costs to Medicare. The CMS Innovation Center will collect and monitor quality measures to maximize the ability to detect successes, protect patients, better serve populations,

[6] Cromwell J., Dayhoff DA., McCall NT, et al. Medicare Participating Heart Bypass Center Demonstration: Final Report. Prepared by Health Economics Research, Inc. 1998.
Abt Associates, Inc., Medicare Cataract Surgery Alternate Payment Demonstration: Final Evaluation Report, Cambridge, Mass: Abt Associates, Inc; 1997.
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Medicare Acute Care Episode Demonstration.
http://www.cms.gov/DemoProjectsEvalRpts/downloads/ACESolicitation.pdf.

and generate useful information to support care design. The initiative is using the Continuity Assessment and Record Evaluation (CARE) Tool to better understand and monitor the beneficiary's experience of care and outcomes of care. The CARE tool was designed to collect standardized patient clinical and functional information not otherwise available from claims. Finally, the initiative will facilitate opportunities for participants to share their experiences with one another and with participants in other CMS Innovation Center initiatives. Learning networks among awardees will allow awardees to learn best practices from their peers and to further develop their initiatives throughout the agreement period.

Accountable Care Organizations

Accountable Care Organizations (ACOs) are one of the Affordable Care Act's key reforms to improve the delivery of care. ACOs are groups of doctors and other health care providers that have agreed to work together to treat individual patients and better coordinate their care across care settings. They share—with Medicare—any savings generated from lowering the growth in health care costs while improving quality of care including providing patient-centered care. Because savings may only occur if acute and post-acute and other care providers work together, ACOs help encourage well-coordinated care across the care continuum.

In just over a year, over 250 ACOs have been formed and are working to improve the care experience for more than four million Medicare fee-for-service beneficiaries nationwide. This is approximately eight percent of all beneficiaries in the Medicare program, and will grow over time as existing ACOs choose to add providers and more organizations are approved for participation in the program. They are located in 47 states and territories—from the most remote community in Montana to Puerto Rico.

The new ACOs include a diverse cross-section of physician practices across the country. Roughly half of all ACOs are physician-led organizations that serve fewer than 10,000 beneficiaries. Approximately 20 percent of ACOs include community health centers, rural health clinics and critical access hospitals that serve low-income and rural communities.

The Shared Savings Program requires that participants —which can be providers, hospitals, suppliers, and others— coordinate care for all services provided under Medicare FFS and encourages investment in infrastructure and redesigned care processes. ACOs that lower their growth in health care costs, while also meeting clearly defined performance standards on health care quality, are eligible to keep a portion of the savings they generate for the program. As a result of these efforts we are seeing providers developing strategies to work together to redesign care processes, promote preventive care, and better coordinate services for patients with chronic disease and high risk individuals.

In addition to the ACOs participating in the Shared Savings Program, the CMS Innovation Center is testing a different payment model for ACOs, the Pioneer ACO model. The Pioneer ACO model is designed for health care organizations that have experience coordinating care for patients across care settings. This model tests alternative payment models that include escalating levels of financial accountability. One purpose of the Pioneer ACO model is to inform future changes to the Shared Savings Program. Thirty-two organizations are participating in the testing of the Pioneer ACO model.

The Innovation Center is also testing the Advance Payment ACO model. The Advance Payment ACO model examines whether and how pre-paying a portion of future shared savings could increase participation in the Shared Savings Program from entities such as physician-owned and rural providers with less capital. Through the Advance Payment ACO Model, selected participants receive upfront and monthly payments, which they can use to make important investments in their care coordination infrastructure. It is our hope that the assistance the Advanced Payment Model provides to smaller and rural practices will result in expanding access to this coordinated care effort to more fee-for-service Medicare beneficiaries. Currently 35 ACOs are participating in this model.

Health Care Innovation Awards

The CMS Innovation Center is also testing new ways to efficiently deliver care and lower costs through its Health Care Innovation Awards. Round One of these three-year awards focused on engaging a broad set of innovation partners to test new care delivery and payment models;

identify new models of workforce development and deployment; and support innovators who can rapidly deploy care improvement models through new ventures or expansion of existing efforts to new patient populations. Grants ranging from $1 million to $30 million were announced in May and June, 2012, to 107 total participants. For example, the University of North Texas Health Science Center, in partnership with Brookdale Senior Living (BSL), received a Health Care Innovation Award to help identify, assess, and manage clinical conditions to reduce preventable hospital admissions and readmissions for residents living in independent living, assisted living and dementia specific facilities. The goal of the program is to prevent the progress of disease, thereby reducing complications, improving care, and reducing the rate of avoidable hospital admissions for older adults. Building on the success of its first round, on May 15, 2013, the CMS Innovation Center announced Round Two of the Health Care Innovation Awards. In Round Two, the CMS Innovation Center is seeking proposals in four categories: models that are designed to rapidly reduce Medicare, Medicaid, and CHIP costs in outpatient and post-acute settings; models that improve the health of populations, defined geographically or by socioeconomic class; models that test approaches for specific types of providers to transform their financial and clinical models; and models that improve care for populations with specialized needs.

Independence at Home Demonstration

The Independence at Home Demonstration, created by the Affordable Care Act and conducted by the CMS Innovation Center, is testing a service delivery and payment incentive model that uses home-based primary care teams designed to improve health outcomes and reduce expenditures for Medicare beneficiaries with multiple chronic conditions. The home-based primary care teams are directed by physicians and nurse practitioners. The Demonstration will award incentive payments to healthcare providers who succeed in reducing Medicare expenditures and meet designated quality measures. The Innovation Center selected a total of 18 individual practices and consortia to participate in the Independence at Home Demonstration.

Post-Acute Care Proposals in the President's FY 2014 Budget

The President's FY 2014 Budget contains many proposals to improve provider payments and encourage appropriate use of post-acute care in order to reduce Medicare costs while protecting

beneficiary access. These proposals would align payments with the cost of care, strengthen provider incentives to promote high-quality care, and encourage beneficiaries to seek high-value care. Together, these proposals would save $94.6 billion over ten years.[7]

Adjust Payment Updates for Certain Post-Acute Providers

MedPAC analysis shows that Medicare payment significantly exceeds the costs of care in post-acute settings, while also finding historically high Medicare profit margins for post-acute care providers. In 2011, IRFs had a 9.6 percent Medicare margin, and the aggregate LTCH Medicare margin was 6.9 percent. Aggregate Medicare profit margins for SNFs have been above 10 percent for 11 years since 2000, and MedPAC has found that the variation in Medicare margins is not related to differences in patient characteristics. In 2011, HHA Medicare profit margins in aggregate were 14.8 percent for freestanding agencies, averaging 17.7 percent from 2001 through 2010.

This proposal would gradually realign payments with costs through adjustments to payment rate updates. It would gradually reduce market basket updates for IRFs, SNFs, LTCHs, and HHAs by 1.1 percent in each year in 2014 through 2023. Payment updates for post-acute care providers would not drop below zero under this proposal.

Encourage Appropriate Use of IRFs

IRFs receive higher payment rates than other medical facilities, including SNFs which often provide care similar to that provided by IRFs for those IRF patients that are not part of the "60 percent rule." As such, we believe that facilities that are paid as IRFs should predominantly provide services to patients requiring more intensive care than can be provided at other medical facilities. Under current law, the classification criteria for IRFs require that at least 60 percent of an IRF's patients need intensive rehabilitation services for treatment of one or more of 13 specified conditions. After an initial phase in period, this classification requirement was originally set to peak at 75 percent, but was later reduced to no more than 60 percent by the Medicare, Medicaid, and SCHIP Extension Act of 2007. If adopted, the proposal would return

[7] Department of Health and Human Services (2013) *FY 2014 Budget in Brief*. p. 54, Retrieved (May 28, 2013) at http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf

the classification standard maximum to 75 percent to ensure that Medicare-paid IRFs are even more focused on treating patients who require specialized, intensive care that would justify the higher payments to IRFs.

Equalize Payments for Certain Conditions Treated in IRFs and SNFs

Currently, treatment of certain knee, hip and pulmonary conditions that do not require intensive therapeutic post-acute care can be performed in either an IRF or an SNF, but Medicare payments are much higher if the treatment occurs in an IRF. This proposal would encourage care delivery in the most clinically appropriate and cost-effective setting. It would, beginning in 2014, make Medicare payments more equal for certain knee, hip, and pulmonary conditions, as well as other conditions selected by the Secretary. These conditions are commonly treated at both IRFs and SNFs.

Adjust SNF Payments to Reduce Hosptial Readmissions

The Affordable Care Act required payment adjustments for inpatient hospitals with high rates of readmissions, many of which could be avoided through better care. This proposal would create a comparable program for SNFs, which have a crucial role in preventing unnecessary hospital readmissions. MedPAC analysis shows that nearly 14 percent of Medicare patients that are discharged from a hospital to a SNF are readmitted to the hospital for conditions that could have been avoided. This proposal would align incentives for better care in skilled nursing facilities by reducing payments in facilities with high rates of hospital readmissions. Beginning in FY 2017, this proposal would reduce payments by up to three percent for SNFs with high rates of care-sensitive preventable hospital readmissions.

Implement Bundled Payment for Post-Acute Care Providers

Bundling episode of care payments can incentivize care coordination and appropriate and accurate payment. This proposal would implement bundled payment for post-acute care providers, including LTCHs, IRFs, SNFs, and home health providers, beginning in 2018. Payments would be bundled for at least half of the total payments made to post-acute care providers. The Secretary would specify the payment rate for an episode of care based on patient characteristics and other factors. The Secretary will have authority to adjust payments based on

quality of care, geographic differences in labor and other costs, and other factors as deemed appropriate.

Bundled payment rates would produce a 2.85 percent cumulative reduction in total payments to post-acute care providers by 2020. Beneficiary coinsurance levels would remain the same as those under current law (for instance to the extent the beneficiary uses SNF services, they would be responsible for the current law copayment rate).

Introduce Home Health Copayments for New Beneficiaries

Home health services represent one of the few areas in Medicare that do not currently include some beneficiary cost-sharing. This proposal aims to encourage appropriate use of home health services while protecting beneficiary access. It would create a co-payment for new beneficiaries of $100 per home health episode, starting in 2017. Consistent with MedPAC recommendations, this co-payment would apply only for episodes with five or more visits not preceded by a hospital or inpatient post-acute stay.

Conclusion

Post-acute care spending growth and geographic variation make controlling post-acute spending a key task for CMS. Better management and better alignment of payment with costs and attention to incentives will be key parts of successful Medicare reform. Using new tools provided in the Affordable Care Act, CMS is taking a holistic approach to post-acute spending through bundled payments and ACOs, both of which emphasize post-acute care as one aspect of a broader care continuum. At the same time, CMS is taking some more targeted actions, including rulemaking that change post-acute care payment systems to more accurately record and value post-acute care. The President's FY 2014 Budget takes these reforms a step further, proposing changes that would incentivize care delivery in the most efficient care setting, reduced readmissions, and better coordination of care. While these initiatives and proposals represent important first steps, more work remains to be done to make Medicare spending on post-acute care sustainable for the long term and improve the overall delivery of care. We look forward to working with the Subcommittee to continue to ensure access to high quality health care for all Medicare beneficiaries.